DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 7/02/10

PRINTED: 05/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445390	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICKETT CARE AND REHABILITATION CENTER	129 HILLCREST DRIVE BYRDSTOWN, TN 38549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the corridor doors. The findings included: During the facility tour on 5/16/10 the following deficiencies were noted and verified by the Director of Maintenance. At 9:25 AM, observation of the wing 3 bath/shower room and the HR office revealed the doors were being held open with pegs. National Fire protection Association (NFPA). 101, 7.2.1.8.1	K 018	**K018** **Corrective Actions for residents affected:** The doors cited were immediately 'un-pegged' by Maintenance Supervisor on 5/16/10. Staff member was instructed by Maintenance Supervisor to keep door closed and not to peg door open. **Identification of residents with potential to be affected:** On 5/16/10 the Maintenance Supervisor examined all other doors to ensure that doors were not pegged open. No other concerns were discovered. **Measures to prevent reoccurrence:** A weekly check will be conducted by the Maintenance Supervisor to ensure that doors affected by NFPA 101, 7.2.1.8.1 are closed with corrections facilitated if needed. In-services will be held 6/3/10 to cover the requirement that doors affected by NFPA 101, 7.2.1.8.1 not be pegged open at any time. **Monitoring of Corrective Action:** As a means of Quality Assurance the Maintenance Supervisor will report findings of door checks to the monthly Safety Committee with corrective actions taken by the Safety Committee if needed.	6/3/10
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/25/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025 SS=D	Continued From page 1 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the smoke barriers. The findings included: During the facility tour on 5/16/10 the following deficiencies were noted and verified by the Director of Maintenance. At 9:45 AM, observation of the area above the smoke doors in wing 3 revealed a penetration in the wall. National Fire Protection Association (NFPA). 101, 8.3.2	K 025	**K025** **Corrective Actions for residents affected:** On 5/17/10, The Maintenance Supervisor took old caulking out from around the wire on wing 3 as cited in the 2567 and replaced with new fire rated caulking. **Identification of residents with potential to be affected:** On 5/17/10 the Maintenance Supervisor examined all other fire walls to ensure no penetrations exist. No other concerns were discovered. **Measures to prevent reoccurrence:** The Maintenance Supervisor will conduct semi-annual checks of the condition of the firewalls. These checks will include an examination of the caulking condition to ensure compliance. **Monitoring of Corrective Action:** As a means of Quality Assurance the Maintenance Supervisor will report findings to the monthly Safety Committee in the months the semi-annual check is conducted.	5/17/10
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are	K 050	**K 050** **Corrective Actions for residents affected:** The Maintenance Supervisor and Administrator directly addressed the findings by immediately instructing the staff member involved with the fire drill to loudly vocalize the code and location and to contain the fire. Administrator also corrected staff who allowed visitor to enter the facility during the drill.	

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K 050	Continued From page 2 conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain train the staff in fire drills. The findings included: During the facility tour on 5/16/10 the following deficiencies were noted and verified by the Director of Maintenance. AT 9:55 AM, observation during the fire drill revealed the staff did not call out code red, the location of the fire, close the door to the fire and allowed a visitor to enter the facility during the fire drill. National Fire Protection Association (NFPA). 101, 19.7.2.3	K 050	K50 continued **Identification of residents with potential to be affected:** In-servicing for all staff regarding loudly vocalizing emergency codes and fire location, fire containment, and securing entrance doors will be held on 6/3/10 and conducted by the Administrator. **Measures to prevent reoccurrence:** 1. As previously stated above: In-servicing for all staff will include: a) Loudly vocalizing fire code and location. b) Fire/smoke containment. c) Securing facility to prevent visitor entrance into the facility. In-service training will be held on 6/3/10 and conducted by the Administrator. 2. Fire drills will be conducted by the Maintenance Supervisor to include tracking and training for the following: a) Loudly vocalizing fire code and location. b) Fire/smoke containment. c) Securing facility to prevent visitor entrance into the facility. **Monitoring of Corrective Action:** As a means of Quality Assurance the Maintenance Supervisor will report fire drill compliance/issues to the monthly Safety Committee.	6/3/10
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the fire extinguishers. The findings included: During the facility tour on 5/16/10 the following	K 064	**K064** **Corrective Actions for residents affected:** The fire extinguishers cited on the 2567 were relocated in accordance with the 60-inch rule by Maintenance Supervisor on 5/17/10. The fire extinguishers in laundry room were relocated for access by the Maint. Supervisor on 5/17/10 (the Admin. checked the 60-inch rule on relocated extinguishers 5/25/10)	

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K 064	Continued From page 3 deficiencies were noted and verified by the Director of Maintenance. At 9:15 AM, observation of the dining room revealed the 2 fire extinguishers were mounted above the 60-inch rule. National Fire protection Association (NFPA). 10, 1.6.10 At 9:30 AM, observation of the laundry area revealed the 2 fire extinguishers were blocked with a table and a trash can. NFPA 10, 1.6.3	K 064	**K64 - Identification of residents with potential to be affected:** On 5/17/10 the Maintenance Supervisor examined all other fire extinguishers for accessibility in accordance with NFPA 10, 1.6.3 and for the 60-inch rule (NFPA 10, 1.6.10) with no other concerns found. **Measures to prevent reoccurrence:** 1. All fire extinguisher relocations will be done the by the Maintenance Supervisor who will follow the 60-inch rule as stated by NFPA 10, 1.3.10. A quality assurance check will be done by the Administrator to assure 60-inch rule compliance following the relocation of any extinguisher. 2. In servicing will be conducted by the Administrator on access to fire emergency equipment on **6/3/10.** The Maintenance Supervisor placed caution tape on the floor to mark off areas to fire emergency equipment in laundry room on 5/25/10. Staff will be instructed to recognize taped off areas as off limits for obstructions on **6/3/10.** **Monitoring of Corrective Action:** As a means of Quality Assurance the Maintenance Supervisor reports findings of the monthly safety checklist regarding access to emergency equipment to the monthly Safety Committee.	6/3/10
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to comply with the electrical codes. The findings included: During the facility tour on 5/16/10 the following deficiencies were noted and verified by the Director of Maintenance. At 9:10 AM, observation of the dining room revealed the electrical panel was blocked with a table. National Fire Protection Association (NFPA). 70, 110-26(a) At 10:35 AM, observation of the 2 wing nurses' office revealed a broken light cover. NFPA 70, 110-12	K 147	**K 147** **Corrective Actions for residents affected:** 1. Items blocking electric panels were removed by Maint. Supervisor on 5/16/10. 2. The Maint. Supervisor replaced light cover on 5/17/10. **Identification of residents with potential to be affected:** 1. On 5/17/10 the Maint. Supervisor examined all other electrical panels for accessibility in accordance with NFPA 70, 110-26(a) with no other concerns found. 2. On 5/17/10 the Maint. Supervisor examined all other light covers in accordance with NFPA 70, 110-12 with no other concerns found.	6/3/10

K147 - Measures to prevent reoccurrence:

1. The Maintenance Supervisor placed caution tape on the floor on 5/25/10 to mark off excess area to electrical panels in the facility. Staff will be instructed to recognize taped off areas as 'off limits' for obstructions on 6/3/10.
2. As part of our safety program a monthly check will be conducted by the Maintenance Supervisor/Administrator to examine the building for maintenance/safety concerns for NFPA 70, Code 9.1.2, for scheduled repairs/service as needed.

Monitoring of Corrective Action:
As a means of Quality Assurance the Maintenance Supervisor will report quality check findings to the monthly Safety Committee.